AccuReview

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Notice of Independent Review Decision

[Date notice sent to all parties]: April 2, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral third occipital nerve block 3, 4 medial branch block 64490, 64491, 64492

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This physician is Board Certified in Anesthesiology with over 8 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
09-19-14: History and Physical. Reason for admission: dysarthria post fall. The claimant is a female with no significant past medical history, who was at work when she tripped and fell on her right forehead, developing a mild contusion and apparently was shaken by the incident. EMS were called. Claimant began to have difficulty with her speech upon arriving at the hospital, today she still has significant dysarthria. Weakness is noted in the right upper extremity is weaker than the left. Claimant complained of pain in the lower back and in her left shoulder blade area. PE: Neurologic: The claimant has 4/5 weakness in the right upper extremity and noted difficulty moving lower extremities secondary to low back pain. Assessment: chronic low back pain, s/p fall with dysarthria and right sided weakness, which is improving. Plan: monitor for fall precautions, monitor dysarthria and weakness for progression and if worsens MRI of brain, TPA not recommended for this claimant, acute exacerbation of low back pain, and gastrointestinal and DVT prophylaxis will be given.

09-19-14: CT C-Spine W/O Contrast. Impression: 1. Anterior longitudinal ligament, posterior longitudinal ligament, ligamentum flavum, and mnuchal interspinous ligaments intact. 2. No cord hematoma or contusion. 3. No disc herniation.

09-20-14: MRA Head WO Contrast. Impression: 1. Several small focal flair hyperintensities in the subcortical white matter bilaterally; findings in a patient of this age are nonspecific and could be due to a variety of etiologies. 2. No focal diffusion restriction to suggest acute infarction. 3. No extra-aodal fluid collection or midline shift is identified. 4. No mucosal thickening ethmoid and frontal sinuses.

09-20-14: MRI L-Spine W/WO Contrast. Impression: 1. No evidence of acute process in the lumbar spine identified. 2. Moderate desiccation/dehydration of the L5-S1 disc consistent with degenerative change; slight 2 mm midline bulging; Modic type 1 endplate changes consistent with degenerative stress reaction. 3. Unremarkable upper lumbar spinal canal and conus medullaris. 4. No evidence of abnormal marrow infiltration/edema. 5. No evidence of bony foraminal narrowing or stenosis. 6. No abnormal paraspinal soft tissue mass identified. 7. No evidence of abnormal contrast enhancement.

is awake, FC x/ weakness noted x 4 R > L. Stuttering speech. Walked halls with PT but became dizzy. Has had 1 episode of vomiting today. Having pain to lower back and requesting pain meds at this time. PE: Neurological: drowsy, A/O x3, stuttering speech w/dysarthria. Weakness x 4 ext R>L. Drowsy but cooperative. Stable to step down and transfer out of critical care.

09-23-14: Progress Note. CC: follow up of fall , confusion, headache and chronic back pain. Subjective: Claimant's slurred speech is significantly improving and is also able to walk with therapy in the hallway. She continues to have some mild headaches with nausea and vomiting. Neck pain is controlled by Norco. Assessment and Plan: S/P fall with underlying degenerative L spine disease, on chronic narcotics, she is controlled on pain medication and is able to ambulate in hallway. Slurred speech, probably had no evidence of stroke on MRI, clinically the patient is improving. Continue PT to treat and evaluate as needed. Add Fiorcet for headache that may be secondary to contusion.

09-30-14: Transcription. CC: head injury onset 9/19/14. ROS: Eyes: blurred vision and photophobia; musculoskeletal: joint pain and muscle weakness, neurological: headache, dizziness, confusion, tingling and impaired balance, speech disturbance. Claimant has chronic back issues which she is on oxycodone and was given hydrocodone and also butalbutal for pain and headaches, she has not seen neurologist yet. PE: Musculoskeletal: Hip: tenderness on the right, but no swelling on the right, full ROM on the right and no weakness on the right. Right wrist: flexion painful, radial deviation painful. Assessment: 1. Contusion to face 920, 2. Problems with communication (including speech) V40.1, 3. Wrist sprain, 842.00, 4. Contusion, hip 924.01. Plan:

neurology referral, PT referral, wrist formfit brace, x-rays right wrist complete, follow up in one week.

11-21-14: Transcription. Current medications: meloxicam 7.5mg, cyclobenzaprine HCL 10 mg, Tramadol HCL 50 mg. CC: Claimant reported her neck and head are still hurting a lot and she responded well to e-stim last session. Neurovascular Screen: Sensation: lateral neck C4 light touch sensation is hyposensitive on the right; lateral shoulder C5 light touch sensation is hyposensitive on the right; 4^{th}, 5^{th} digit C6 light touch sensation is hyposensitive on the right; medial forearm T1 light touch sensation is hyposensitive on the right. Myotomes: C2-C4, C5, C6, C7, C8, and T1 are all diminished on the right. Joint mobility: C4-5 hypomobile on the R x/ side gliding, pain. Current pain 7/10. Evaluation: 1. Cervical strain 847.0, 2. Contusion, hip 924.01, 3. Falls on same level from slipping, tripping or stumbling E885.9, 4. Problems with communication (including speech) V40.1, 5. Shoulder contusion 823.00, 6. Wrist sprain 842.00.

12-31-14: Office Visit. Claimant complained of constant neck pain, along with headaches and a constant ringing in her ears after an injury at work on 9/19/14 in which she fell from standing and struck her head. Her pain is made worse by noise and light and relieved by nothing. She complained of tingling in her fingers bilaterally. Current medications: Amitriptyline HCL 25mg, Gabapentin 600mg, celexa 10mg, morphine sulfate ER 60mg. Current pain 10/10. PE: Neck: normal cervical lordosis; shoulder girdles symmetric; decreased AROM to extension, rotation and lateral bending 2/2 pain; +TTP over B cervical paraspinals and upper cervical facet joints. Assessment: Cervical spondylosis without myelopathy 721.0. Likely 2/2 cervical facet syndrome. Recommend cervical facet injections bilateral C2-3 and C3-4. RTC 2 weeks.

01-26-15: Operative Report. Preoperative Diagnosis: cervical spondylosis without myelopathy 721.0. Postoperative Diagnosis: same.

02-16-15: Office Visit. Claimant stated injection gave 100% relief for the first day and now still having severe headaches and ringing in her ears at all times. Pain is currently 9/10. Assessment: R>L posterior axial NP, with headaches, aggravated by cervical extension and axial rotation with + upper cervical facet TTP. No lasting therapeutic relief from injection. She is currently working full duty without restrictions. She is requesting narcotic pain medications. She is currently under for low back pain and taking MSER 60mg. Therefore will not give narcotics. Plan: The claimant is having cervicogenic headaches and neck pain caused by cervical facet syndrome. She did get great anesthetic relief after facet steroid injections, but did not het therapeutic relief from the steroid. Recommend prior authorization for bilateral TON, C3 and C4 medial branch blocks for diagnostic evaluation of the C23, 34 facet joints. She would be a candidate for radiofrequency neurotomy at these levels if she gets at least 70% anesthetic phase relief. Follow up post procedure.

02-24-15: UR. Reason for denial: There is lack of clinical documentation showing a recent trail and failure of conservative treatment including home

exercise, physical therapy, and NSAIDs prior to the procedure for at least 4-6 weeks. While the documentation indicated a plan for the claimant to undergo a facet neurotomy if the requested therapy is successful, without documentation of failure of conservative treatment, the request is not supported. In the absence of this information, medical necessity for the request cannot be established. As such, the request for bilateral third occipital nerve block 3, 4 medial branch block is non-certified.

02-27-15: UR. Based on the clinical information provided, the appeal request for bilateral third occipital nerve block 3, 4 medial branch block is not recommended as medically necessary. The initial request was non-certified noting that there is a lack of documentation showing a recent trial and failure of conservative treatment including home exercise, physical therapy and NSAIDs prior to the procedure for at least 4-6 weeks. While the documentation indicates a plan for the claimant to undergo a facet neurotomy if the requested therapy is successful, without documentation of failure of conservative treatment, the request is not supported. There is insufficient information to support a change in determination, and the previous non-certification is upheld. There is no indication that the claimant has received any recent treatment. The ODG requires documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. In regards to third occipital nerve block, the ODG note that this procedure is under study. The submitted records fail to establish presence of occipital neuralgia or corvicogenic headaches.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse determinations are upheld and agreed upon. In order to certify this request, there must be documentation that demonstrates failure of conservative therapy including home exercise, physical therapy and NSAIDs prior to the procedure for at least 4-6 weeks. While the documentation indicates a plan for the claimant to undergo a facet neurotomy if the requested therapy is successful, without documentation of failure of conservative treatment, this request is non-certified. There is no indication that the claimant has received any recent treatment. In regards to third occipital nerve block, the ODG note that this procedure remains investigational. Additionally, the submitted records fail to establish presence of occipital neuralgia or cervicogenic headaches. Therefore, after reviewing the medical records and documentation provided, the request for Bilateral third occipital nerve block 3, 4 medial branch block 64490, 64491, 64492 is denied.

Per ODG:

Greater occipital nerve block, diagnostic	Under Study. Greater occipital nerve blocks (GONB) have been recommended by several organizations for the diagnosis of both occipital neuralgia and cervicogenic headaches. It has been noted that both the International Association for the Study of Pain and World Cervicogenic Headache Society focused on relief of pain by analgesic injection into cervical structures, but there was little to no consensus as to what injection technique should be utilized and lack of convincing clinical trials to aid in

	this diagnostic methodology. (Haldeman, 2001) Difficulty arises in that occipital nerve blocks are non-specific. This may result in misidentification of the occipital nerve as the pain generator. (Biondi, 2005) (Leone, 1998) (Aetna, 2006) In addition, there is no research evaluating the block as a diagnostic tool under controlled conditions (placebo, sham, or other control). (Bogduk, 2004) An additional problem is that patients with both tension headaches and migraine headaches respond to GONB. In one study comparing patients with cervicogenic headache to patients with tension headaches and migraines, pain relief was found by all three categories of patients (54.5%, 14% and 6%, respectively). Due to the differential response, it has been suggested that GONB may be useful as a diagnostic aid in differentiating between these three headache conditions. (Bovim, 1992) See also Greater occipital nerve block, therapeutic and the Head Chapter.
Facet joint diagnostic blocks	**Criteria for the use of diagnostic blocks for facet nerve pain:** Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of ≥ 70%. The pain response should be approximately 2 hours for Lidocaine. 2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a “sedative” during the procedure. 8. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. 12. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**